BILL NUMBER: AB 1629 CHAPTERED
BILL TEXT

CHAPTER 875
FILED WITH SECRETARY OF STATE SEPTEMBER 29, 2004
APPROVED BY GOVERNOR SEPTEMBER 29, 2004
PASSED THE ASSEMBLY AUGUST 28, 2004
PASSED THE SENATE AUGUST 25, 2004
AMENDED IN SENATE AUGUST 24, 2004
AMENDED IN SENATE AUGUST 16, 2004
AMENDED IN SENATE JULY 16, 2003
AMENDED IN ASSEMBLY JUNE 2, 2003
AMENDED IN ASSEMBLY APRIL 28, 2003

INTRODUCED BY Assembly Member Frommer
(Coauthors: Assembly Members Berg, McCarthy, Nunez, Richman, and Strickland)
(Coauthors: Senators Burton and Johnson)

FEBRUARY 21, 2003

An act to add Section 1418.81 to, and to add and repeal Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of, the Health and Safety Code, and to amend Section 14105.06 of, to add and repeal Section 14126.033 of, and to repeal and add Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health and dependent care, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1629, Frommer. Health and dependent care facilities.

Existing law provides for the licensure and regulation of health facilities by the State Department of Health Services. Existing law provides for the imposition each state fiscal year upon the entire

gross receipts of certain intermediate care facilities a quality assurance fee, as a condition of participation in the Medi-Cal program.

This bill would provide for the imposition of a quality assurance fee on each skilled nursing facility, with some exemptions, to be administered by the Director of Health Services and deposited in the State Treasury. The bill would provide that funds assessed pursuant to these provisions shall be available to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and support facility quality improvement efforts in, licensed skilled nursing facilities. The bill would provide that these provisions are to be implemented as long as 2 conditions are met, including federal approval. The bill would also specify 4 circumstances, concerning continued federal approval of the quality assurance fee, the enactment and continued effect of the Medi-Cal Long-Term Reimbursement Act under this bill, the failure of the state to sustain a continued maintenance of effort for state funding of nursing facility reimbursement, and any judicial or federal administrative determinations regarding the unavailability of federal financial participation, under which these provisions would become inoperative. In addition, these provisions would become inoperative on July 1, 2008, and would be repealed on January 1, 2009.

Existing law requires the department to perform various activities to promote the quality of care and life of residents, clients, and patients in these facilities.

This bill would require a skilled nursing facility to include in a resident's care assessment the resident's projected length of stay and the resident's discharge potential. The bill would specify additional requirements of a skilled nursing facility and attending physicians at the facility related to resident assessment, care planning, and assistance. The bill would also require the attending physician, if applicable, to indicate in the plan of care the needed care to assist the resident in achieving a resident's preference of return to the community.

Existing law provides for the Medi-Cal program, which is administered by the department and pursuant to which qualified low-income persons receive health care benefits. Existing law required that the Medi-Cal reimbursement rates in effect on August 1,

2003, remain in effect through July 31, 2005, for, among others, freestanding nursing facilities licensed as skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the developmentally disabled.

This bill would delete skilled nursing facilities from the application of this reimbursement rate limitation and would, instead, provide that the reimbursement rate limitation applies to skilled nursing facilities only until the first day of the month following federal approval to implement both the skilled nursing quality assurance fee and the rate methodology.

Existing law provides for the Medi-Cal Long-Term Reimbursement Act of 1990 under which the department is required to develop a reimbursement methodology for freestanding nursing facilities licensed as skilled nursing facilities and intermediate care facilities, and for intermediate care facilities for the developmentally disabled. These provisions, among other things, require the department to implement a facility specific ratesetting system by August 1, 2004, subject to federal approval and the availability of federal or other funds.

This bill would repeal these provisions. The bill would enact the Medi-Cal Long-Term Reimbursement Act, to be under the administration of the director. The act would require the department to implement a facility specific ratesetting system, subject to federal approval, that would be effective commencing on August 1, 2005, and implemented commencing on the first day of the month following federal approval.

The bill would authorize the department to retroactively increase and make payment of rates to facilities under this provision. The act would require the department to develop and implement a cost-based reimbursement rate methodology for free standing nursing facilities. The act would require the department to seek approval of a Medicaid state plan amendment specifically outlining the reimbursement methodology developed pursuant to these provisions and would provide that this methodology shall be effective commencing on August 1, 2005, and implemented on the first day of the month following federal approval. The act would provide that it shall remain operative only as long as the skilled nursing facility quality assurance fee provisions provided by the bill continues as approved by the federal Centers for Medicare and Medicaid Services and federal

financial participation for the methodology implemented under these provisions continues. The rate methodology established pursuant to these provisions would cease to be implemented on and after July 31, 2008.

The bill would make the following appropriations:

(a) $106,781,000 from both the State Treasury and the Federal Trust Fund to the department for expenditure to fund an increase to the 2004-05 skilled nursing facility Medi-Cal reimbursement rate consistent with the existing rate methodology in the Medicaid state plan.

(b) $2,000,000 for the 2004-05 fiscal year and $1,000,000 for the 2005-06 fiscal year to the department from the General Fund for expenditure for purposes of expeditiously implementing the ratesetting system that would be required under this bill.

(c) $350,000 for both the 2004-05 fiscal year and the 2005-06 fiscal year to the department from the General Fund for expenditure for purposes of funding the implementation of the bill.

(d) $200,000 for the 2005-06 fiscal year to the Bureau of State Audits from the General Fund for purposes of implementing the bill.

This bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Article 7.6 (commencing with Section 1324.20) is added to Chapter 2 of Division 2 of the Health and Safety Code, to read:

Article 7.6. Skilled Nursing Facility Quality Assurance Fee

1324.20. For purposes of this article, the following definitions shall apply:

(a) "Continuing care retirement community" means a provider of a continuum of services, including independent living services, assisted living services as defined in paragraph (5) of subdivision (a) of Section 1771, and skilled nursing care, on a single campus,

that is subject to Section 1791, or a provider of such a continuum of services on a single campus that has not received a Letter of Exemption pursuant to subdivision (b) of Section 1771.3.

(b) "Exempt facility" means a skilled nursing facility that is part of a continuing care retirement community, a skilled nursing facility operated by the state or another public entity, or a skilled nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital.

(c) (1) "Net revenue" means gross resident revenue for routine nursing services and ancillary services provided to all residents by a skilled nursing facility, less Medicare revenue for routine and ancillary services including Medicare revenue for services provided to residents covered under a Medicare managed care plan, less payer discounts and applicable contractual allowances as permitted under federal law and regulation.

(2) "Net revenue" does not mean charitable contributions and bad debt.

(d) "Payer discounts and contractual allowances" means the difference between the facility's resident charges for routine or ancillary services and the actual amount paid.

(e) "Skilled nursing facility" means a licensed facility as defined in subdivision (c) of Section 1250.

1324.21. (a) For facilities licensed under subdivision (c) of Section 1250, there shall be imposed each state fiscal year a uniform quality assurance fee per resident day. The uniform quality assurance fee shall be based upon the entire net revenue of all skilled nursing facilities subject to the fee, except an exempt facility, as defined in Section 1324.20, calculated in accordance with subdivision (b).

(b) The amount of the uniform quality assurance fee to be assessed per resident day shall be determined based on the aggregate net revenue of skilled nursing facilities subject to the fee, in accordance with the methodology outlined in the request for federal approval required by Section 1324.27 and in regulations, provider bulletins, or other similar instructions. The uniform quality assurance fee shall be calculated as follows:

(1) (A) For the rate year 2004-05, the net revenue shall be projected for all skilled nursing facilities subject to the fee. The

projection of net revenue shall be based on prior rate year data. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 2.7 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee.

(B) Notwithstanding subparagraph (A), the Director of Health Services may increase the amount of the fee up to 3 percent of the aggregate projected net revenue if necessary for the implementation of Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) For the rate year 2005-06 and subsequent rate years through and including the 2007-08 rate year, the net revenue shall be projected for all skilled nursing facilities subject to the uniform quality assurance fee. The projection of net revenue shall be based on the prior rate year's data. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 6 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee.

(c) The director may assess and collect a nonuniform fee consistent with the methodology approved pursuant to Section 1324.27.

(d) In no case shall the aggregate fees collected annually pursuant to this article exceed 6 percent of the annual aggregate net revenue for licensed skilled nursing facilities subject to the fee.

(e) If there is a delay in the implementation of this article for any reason, including a delay in the approval of the quality assurance fee and methodology by the federal Centers for Medicare and Medicaid Services, in the 2004-05 rate year or in any other rate year, all of the following shall apply:

(1) Any facility subject to the fee may be assessed the amount the facility will be required to pay to the department, but shall not be required to pay the fee until the methodology is approved and Medi-Cal rates are increased in accordance with paragraph (2) of subdivision (a) of Section 1324.28 and the increased rates are paid to facilities.

(2) The department may retroactively increase and make payment of

rates to facilities.

(3) Facilities that have been assessed a fee by the department shall pay the fee assessed within 60 days of the date rates are increased in accordance with paragraph (2) of subdivision (a) of Section 1324.28 and paid to facilities.

(4) The department shall accept a facility's payment notwithstanding that the payment is submitted in a subsequent fiscal year than the fiscal year in which the fee is assessed.

1324.22. (a) The quality assurance fee, as calculated pursuant to Section 1324.21, shall be paid by the provider to the department for deposit in the State Treasury on a monthly basis on or before the last day of the month following the month for which the fee is imposed, except as provided in subdivision (d) of Section 1324.21.

(b) On or before the last day of each calendar quarter, each skilled nursing facility shall file a report with the department, in a prescribed form, showing the facility's total resident days for the preceding quarter and payments made. If it is determined that a lesser amount was paid to the department, the facility shall pay the amount owed in the preceding quarter to the department with the report. Any amount determined to have been paid in excess to the department during the previous quarter shall be credited to the amount owed in the following quarter.

(c) On or before August 31 of each year, each skilled nursing facility subject to an assessment pursuant to Section 1324.21 shall report to the department, in a prescribed form, the facility's total resident days and total payments made for the preceding state fiscal year. If it is determined that a lesser amount was paid to the department during the previous year, the facility shall pay the amount owed to the department with the report.

(d) A newly licensed skilled nursing facility, as defined by the department, shall complete all requirements of subdivision (a) for any portion of the year in which it commences operations and of subdivision (b) for any portion of the quarter in which it commences operations.

(e) When a skilled nursing facility fails to pay all or part of the quality assurance fee within 60 days of the date that payment is due, the department may deduct the unpaid assessment and interest owed from any Medi-Cal reimbursement payments to the facility until

the full amount is recovered. Any deduction shall be made only after written notice to the facility and may be taken over a period of time taking into account the financial condition of the facility.

(f) Should all or any part of the quality assurance fee remain unpaid, the department may take either or both of the following actions:

(1) Assess a penalty equal to 50 percent of the unpaid fee amount.

(2) Delay license renewal.

(g) In accordance with the provisions of the Medicaid state plan, the payment of the quality assurance fee shall be considered as an allowable cost for Medi-Cal reimbursement purposes.

(h) The assessment process pursuant to this section shall become operative not later than 60 days from receipt of federal approval of the quality assurance fee, unless extended by the department. The department may assess fees and collect payment in accordance with subdivision (d) of Section 1324.21 in order to provide retroactive payments for any rate increase authorized under this article.

1324.23. (a) The Director of Health Services, or his or her designee, shall administer this article.

(b) The director may adopt regulations as are necessary to implement this article. These regulations may be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). For purposes of this article, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The regulations shall include, but need not be limited to, any regulations necessary for any of the following purposes:

(1) The administration of this article, including the proper imposition and collection of the quality assurance fee not to exceed amounts reasonably necessary for purposes of this article.

(2) The development of any forms necessary to obtain required information from facilities subject to the quality assurance fee.

(3) To provide details, definitions, formulas, and other requirements.

(c) As an alternative to subdivision (b), and notwithstanding the

rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article, in whole or in part, by means of a provider bulletin, or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2007. It is the intent of the Legislature that the regulations adopted pursuant to subdivision (b) shall be adopted on or before July 31, 2007.

1324.24. The quality assurance fee assessed and collected pursuant to this article shall be deposited in the State Treasury.

1324.25. The funds assessed pursuant to this article shall be available to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and to support facility quality improvement efforts in, licensed skilled nursing facilities.

1324.26. In implementing this article, the department may utilize the services of the Medi-Cal fiscal intermediary through a change order to the fiscal intermediary contract to administer this program, consistent with the requirements of Sections 14104.6, 14104.7, 14104.8, and 14104.9 of the Welfare and Institutions Code.

1324.27. (a) (1) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt facilities identified in subdivision (b) of Section 1324.20, including the submission of a request for waiver of broad based requirement, waiver of uniform fee requirement, or both, pursuant to paragraphs (1) and (2) of subdivision (e) of Section 433.68 of Title 42 of the Code of Federal Regulations.

(2) The director may alter the methodology specified in this article, to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval. The Director of Health Services may also add new categories of exempt facilities, such as facilities designated as institutions for mental diseases or special treatment programs, or apply a nonuniform fee to the skilled nursing facilities subject to the fee in order to meet requirements of federal law or regulations. The Director of Health Services may

apply a zero fee to one or more exempt categories of facilities, if necessary to obtain federal approval.

(3) If after seeking federal approval, federal approval is not obtained, this article shall not be implemented.

(b) The department shall make retrospective adjustments, as necessary, to the amounts calculated pursuant to Section 1324.21 in order to assure that the aggregate quality assurance fee for any particular state fiscal year does not exceed 6 percent of the aggregate annual net revenue of facilities subject to the fee.

1324.28. (a) This article shall be implemented as long as both of the following conditions are met:

(1) The state receives federal approval of the quality assurance fee from the federal Centers for Medicare and Medicaid Services.

(2) Legislation is enacted in the 2004 legislative session making an appropriation from the General Fund and from the Federal Trust Fund to fund a rate increase for skilled nursing facilities, as defined under subdivision (c) of Section 1250, for the 2004-05 rate year in an amount consistent with the Medi-Cal rates that specific facilities would have received under the rate methodology in effect as of July 31, 2004, plus the proportional costs as projected by Medi-Cal for new state or federal mandates.

(b) This article shall remain operative only as long as all of the following conditions are met:

(1) The federal Centers for Medicare and Medicaid Services continues to allow the use of the provider assessment provided in this article.

(2) The Medi-Cal Long Term Care Reimbursement Act, Article 3.8 (commencing with Section 14126) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code, as added during the 2003-04 Regular Session by the act adding this section, is enacted and implemented on or before July 31, 2005, or as extended as provided in that article, and remains in effect thereafter.

(3) The state has continued its maintenance of effort for the level of state funding of nursing facility reimbursement for rate year 2005-06, and for every subsequent rate year continuing through the 2007-08 rate year, in an amount not less than the amount that specific facilities would have received under the rate methodology in effect on July 31, 2004, plus Medi-Cal's projected proportional

costs for new state or federal mandates, not including the quality assurance fee.

(4) The full amount of the quality assurance fee assessed and collected pursuant to this article remains available for the purposes specified in Section 1324.25 and for related purposes.

(c) If all of the conditions in subdivision (a) are met, this article is implemented, and subsequently, any one of the conditions in subdivision (b) is not met, on and after the date that the department makes that determination, this article shall not be implemented, notwithstanding that the condition or conditions subsequently may be met.

(d) Notwithstanding subdivisions (a), (b), and (c), in the event of a final judicial determination made by any state or federal court that is not appealed, or by a court of appellate jurisdiction that is not further appealed, in any action by any party, or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services, that federal financial participation is not available with respect to any payment made under the methodology implemented pursuant to this article because the methodology is invalid, unlawful, or contrary to any provision of federal law or regulations, or of state law, this section shall become inoperative.

1324.29. The quality assurance fee shall cease to be assessed and collected on or after July 31, 2008.

1324.30. This article shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 1418.81 is added to the Health and Safety Code, to read:

1418.81. (a) In order to assure the provision of quality patient care and as part of the planning for that quality patient care, commencing at the time of admission, a skilled nursing facility, as defined in subdivision (c) of Section 1250, shall include in a resident's care assessment the resident's projected length of stay and the resident's discharge potential. The assessment shall include whether the resident has expressed or indicated a preference to

return to the community and whether the resident has social support, such as family, that may help to facilitate and sustain return to the community. The assessment shall be recorded with the relevant portions of the minimum data set, as described in Section 14110.15 of the Welfare and Institutions Code. The plan of care shall reflect, if applicable, the care ordered by the attending physician needed to assist the resident in achieving the resident's preference of return to the community.

(b) The skilled nursing facility shall evaluate the resident's discharge potential at least quarterly or upon a significant change in the resident's medical condition.

(c) The interdisciplinary team shall oversee the care of the resident utilizing a team approach to assessment and care planning and shall include the resident's attending physician, a registered professional nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and, where practicable, a resident's representative, in accordance with applicable federal and state requirements.

(d) If return to the community is part of the care plan, the facility shall provide to the resident or responsible party and document in the care plan the information concerning services and resources in the community. That information may include information concerning:

(1) In-home supportive services provided by a public authority or other legally recognized entity, if any.

(2) Services provided by the Area Agency on Aging, if any.

(3) Resources available through an independent living center.

(4) Other resources or services in the community available to support return to the community.

(e) If the resident is otherwise eligible, a skilled nursing facility shall make, to the extent services are available in the community, a reasonable attempt to assist a resident who has a preference for return to the community and who has been determined to be able to do so by the attending physician, to obtain assistance within existing programs, including appropriate case management services, in order to facilitate return to the community. The targeted case management services provided by entities other than the skilled nursing facility shall be intended to facilitate and sustain

return to the community.

(f) Costs to skilled nursing facilities to comply with this section shall be allowable for Medi-Cal reimbursement purposes pursuant to Section 1324.25, but shall not be considered a new state mandate under Section 14126.023 of the Welfare and Institutions Code.

SEC. 3. Section 14105.06 of the Welfare and Institutions Code is amended to read:

14105.06. (a) Notwithstanding Section 14105 and any other provision of law, the Medi-Cal reimbursement rates in effect on August 1, 2003, shall remain in effect through July 31, 2005, for the following providers:

(1) Freestanding nursing facilities licensed as either of the following:

(A) An intermediate care facility pursuant to subdivision (d) of Section 1250 of the Health and Safety Code.

(B) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code.

(2) A skilled nursing facility that is a distinct part of a general acute care hospital. For purposes of this paragraph, "distinct part" shall have the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(3) A subacute care program, as described in Section 14132.25 or subacute care unit, as described in Sections 51215.5 and 51215.8 of Title 22 of the California Code of Regulations.

(4) An adult day health care center.

(b) (1) The director may adopt regulations as are necessary to implement subdivision (a). These regulations shall be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For purposes of this section, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare.

(2) As an alternative to paragraph (1), and Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of

the Government Code, the director may implement this article by means of a provider bulletin, or similar instructions, without taking regulatory action.

(c) The director shall implement subdivision (a) in a manner that is consistent with federal medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approval is obtained.

(d) The provisions of subdivision (a) shall apply to a skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, only until the first day of the month following federal approval to implement both the skilled nursing quality assurance fee imposed by Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code and the rate methodology developed pursuant to Article 3.8 (commencing with Section 14126) of Chapter 3 of Part 3 of Division 9.

SEC. 4. Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code is repealed.

SEC. 5. Article 3.8 (commencing with Section 14126) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 3.8. Medi-Cal Long-Term Care Reimbursement Act

14126. This article shall be known as the Medi-Cal Long-Term Care Reimbursement Act.

14126.02. (a) It is the intent of the Legislature to devise a Medi-Cal long-term care reimbursement methodology that more effectively ensures individual access to appropriate long-term care services, promotes quality resident care, advances decent wages and benefits for nursing home workers, supports provider compliance with all applicable state and federal requirements, and encourages administrative efficiency.

(b) The department shall implement a facility-specific ratesetting system, subject to federal approval and the availability of federal funds, that reflects the costs and staffing levels associated with

quality of care for residents in nursing facilities, as defined in subdivision (c) of Section 1250 of the Health and Safety Code. The facility-specific ratesetting system shall be effective commencing on August 1, 2005, and shall be implemented commencing on the first day of the month following federal approval. The department may retroactively increase and make payment of rates to facilities.

(c) In implementing this section, the department may contract as necessary, on a bid or nonbid basis, for professional consulting services from nationally recognized higher education and research institutions, or other qualified individuals and entities not associated with a skilled nursing facility, with demonstrated expertise in long-term care reimbursement systems. The ratesetting system specified in subdivision (b) shall be developed with all possible expedience. This subdivision establishes an accelerated process for issuing contracts pursuant to this section and contracts entered into pursuant to this subdivision shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(d) The department shall implement a facility-specific ratesetting system by August 1, 2004, subject to federal approval and availability of federal or other funds, that reflects the costs and staffing levels associated with quality of care for residents in hospital-based nursing facilities.

14126.021. The department shall develop and implement a cost-based reimbursement rate methodology using the cost categories as described in Section 14126.023, for freestanding nursing facilities pursuant to this article, excluding nursing facilities that are a distinct part of a facility that is licensed as a general acute care hospital as identified pursuant to subdivision (d) of Section 14126.02. The cost-based reimbursement rate methodology shall be effective on August 1, 2005, and shall be implemented on the first day of the month following federal approval.

14126.023. (a) The methodology developed pursuant to this article shall be facility specific and reflect the sum of the projected cost of each cost category and passthrough costs, as follows:

(1) Labor costs limited as specified in subdivision (c).

(2) Indirect care nonlabor costs limited to the 75th percentile.

(3) Administrative costs limited to the 50th percentile.

(4) Capital costs based on a fair rental value system (FRVS) limited as specified in subdivision (d).

(5) Direct passthrough of proportional Medi-Cal costs for property taxes, facility license fees, new state and federal mandates, caregiver training costs, and liability insurance projected on the prior year's costs.

(b) The percentiles in paragraphs (1) through (3) of subdivision (a) shall be based on annualized costs divided by total resident days and computed on a specific geographic peer group basis. Costs within a specific cost category shall not be shifted to any other cost category.

(c) The labor costs category shall be comprised of a direct resident care labor cost category, an indirect care labor cost category, and a labor-driven operating allocation cost category, as follows:

(1) Direct resident care labor cost category which shall include all labor costs related to routine nursing services including all nursing, social services, activities, and other direct care personnel. These costs shall be limited to the 90th percentile.

(2) Indirect care labor cost category which shall include all labor costs related to staff supporting the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, inservice education, and plant operations and maintenance. These costs shall be limited to the 90th percentile.

(3) Labor-driven operating allocation shall include an amount equal to 8 percent of labor costs, minus expenditures for temporary staffing, which may be used to cover allowable Medi-Cal expenditures. In no instance shall the operating allocation exceed 5 percent of the facility's total Medi-Cal reimbursement rate.

(d) The capital cost category shall be based on a FRVS that recognizes the value of the capital related assets necessary to care for Medi-Cal residents. The capital cost category includes mortgage principal and interest, leases, leasehold improvements, depreciation of real property, equipment, and other capital related expenses. The FRVS methodology shall be based on the formula developed by the department that assesses facility value based on age and condition

and uses a recognized market interest factor. Capital investment and improvement expenditures included in the FRVS formula shall be documented in cost reports or supplemental reports required by the department. The capital costs based on FRVS shall be limited as follows:

(1) For the 2005-06 rate year, the capital cost category for all facilities in the aggregate shall not exceed the department's estimated value for this cost category for the 2004-05 rate year.

(2) For the 2006-07 rate year and subsequent rate years, the maximum annual increase for the capital cost category for all facilities in the aggregate shall not exceed 8 percent of the prior rate year's FRVS cost component.

(3) If the total capital costs for all facilities in the aggregate for the 2005-06 rate year exceeds the value of the capital costs for all facilities in the aggregate for the 2004-05 rate year, or if that capital cost category for all facilities in the aggregate for the 2006-07 rate year or any rate year thereafter exceeds 8 percent of the prior rate year's value, the department shall reduce the capital cost category for all facilities in equal proportion in order to comply with paragraphs (1) and (2).

(e) For the 2005-06 and 2006-07 rate years, the facility specific Medi-Cal reimbursement rate calculated under this article shall not be less than the Medi-Cal rate that the specific facility would have received under the rate methodology in effect as of July 31, 2005, plus Medi-Cal's projected proportional costs for new state or federal mandates for rate years 2005-06 and 2006-07, respectively.

(f) The department shall update each facility specific rate calculated under this methodology annually. The update process shall be prescribed in the Medicaid state plan, regulations, and the provider bulletins or similar instructions described in Section 14126.027, and shall be adjusted in accordance with the results of facility specific audit and review findings in accordance with subdivisions (h) and (i).

(g) The department shall establish rates pursuant to this article on the basis of facility cost data reported in the integrated long-term care disclosure and Medi-Cal cost report required by Section 128730 of the Health and Safety Code for the most recent reporting period available, and cost data reported in other facility

financial disclosure reports or supplemental information required by the department in order to implement this article.

(h) The department shall conduct financial audits of facility and home office cost data as follows:

(1) The department shall audit facilities a minimum of once every three years to ensure accuracy of reported costs.

(2) It is the intent of the Legislature that the department develop and implement limited scope audits of key cost centers or categories to assure that the rate paid in the years between each full scope audit required in paragraph (1) accurately reflects actual costs.

(3) For purposes of updating facility specific rates, the department shall adjust or reclassify costs reported consistent with applicable requirements of the Medicaid state plan as required by Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations.

(4) Overpayments to any facility shall be recovered in a manner consistent with applicable recovery procedures and requirements of state and federal laws and regulations.

(i) (1) On an annual basis, the department shall use the results of audits performed pursuant to subdivision (h), the results of any federal audits, and facility cost reports, including supplemental reports of actual costs incurred in specific cost centers or categories as required by the department, to determine any difference between reported costs used to calculate a facility's rate and audited facility expenditures in the rate year.

(2) If the department determines that there is a difference between reported costs and audited facility expenditures pursuant to paragraph (1), the department shall adjust a facility's reimbursement prospectively over the intervening years between audits by an amount that reflects the difference, consistent with the methodology specified in this article.

(j) For nursing facilities that obtain an audit appeal decision that results in revision of the facility's allowable costs, the facility shall be entitled to seek a retroactive adjustment in its facility specific reimbursement rate.

(k) Compliance by each facility with state laws and regulations regarding staffing levels shall be documented annually either through

facility cost reports, including supplemental reports, or through the annual licensing inspection process specified in Section 1422 of the Health and Safety Code.

14126.025. (a) The department shall seek approval of an amendment to the Medicaid state plan specifically outlining the reimbursement methodology developed pursuant to this article not later than February 1, 2005.

(b) The amendment to the Medicaid state plan pursuant to subdivision (a), and any regulations, provider bulletins, or other similar instructions, shall be prepared in consultation with representatives of the long-term care industry, organized labor, seniors, and consumers.

14126.027. (a) (1) The Director of Health Services, or his or her designee, shall administer this article.

(2) The regulations and other similar instructions adopted pursuant to this article shall be developed in consultation with representatives of the long-term care industry, organized labor, seniors, and consumers.

(b) (1) The director may adopt regulations as are necessary to implement this article. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe specific facts showing the need for immediate action.

(2) The regulations adopted pursuant to this section may include, but need not be limited to, any regulations necessary for any of the following purposes:

(A) The administration of this article, including the specific analytical process for the proper determination of long-term care rates.

(B) The development of any forms necessary to obtain required cost data and other information from facilities subject to the ratesetting methodology.

(C) To provide details, definitions, formulas, and other requirements.

(c) As an alternative to the adoption of regulations pursuant to

subdivision (b), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article, in whole or in part, by means of a provider bulletin or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2007. It is the intent that regulations adopted pursuant to subdivision (b) shall be in place on or before July 31, 2007.

14126.031. (a) In implementing this article, the department may use the process outlined in subdivision (c) of Section 14126.02 to obtain professional consulting services for the purpose of finalizing design of the system, procurement of required technical hardware and software, establishing operational parameters, implementation, and transitional management pending assumption of operational management by state staff.

(b) The ratesetting system described in subdivision (b) of Section 14126.02 shall be developed expeditiously in order to meet the implementation date required under Section 14126.02.

(c) To ensure compliance with the timeframes set forth in this article, it is the intent of the Legislature that the department be authorized to hire up to three full-time equivalents to support implementation and continuous operation of the system.

14126.033. (a) This article, including Section 14126.031, shall be funded as follows:

(1) General Fund moneys appropriated for purposes of this article pursuant to Section 6 of the act adding this section shall be used for increasing rates, except as provided in Section 14126.031, for freestanding skilled nursing facilities, and shall be consistent with the approved methodology required to be submitted to the Centers for Medicare and Medicaid Services pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code.

(2) (A) Notwithstanding Section 14126.023, for the 2005-06 rate year, the maximum annual increase in the weighted average Medi-Cal rate required for purposes of this article shall not exceed 8 percent of the weighted average Medi-Cal reimbursement rate for the 2004-05 rate year as adjusted for the change in the cost to the facility to comply with the nursing facility quality assurance fee for the

2005-06 rate year, as required under subdivision (b) of Section 1324.21 of the Health and Safety Code, plus the total projected Medi-Cal cost to the facility of complying with new state or federal mandates.

(B) Beginning with the 2006-07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(C) Beginning with the 2007-08 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5.5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(D) To the extent that new rates are projected to exceed the adjusted limits calculated pursuant to subparagraph (A) or (B), the department shall adjust the increase to each skilled nursing facility's projected rate for the applicable rate year by an equal percentage.

(b) The rate methodology shall cease to be implemented on and after July 31, 2008.

(c) (1) It is the intent of the Legislature that the implementation of this article result in individual access to appropriate long-term care services, quality resident care, decent wages and benefits for nursing home workers, a stable workforce, provider compliance with all applicable state and federal requirements, and administrative efficiency.

(2) Not later than December 1, 2006, the Bureau of State Audits shall conduct an accountability evaluation of the department's progress toward implementing a facility-specific reimbursement system, including a review of data to ensure that the new system is appropriately reimbursing facilities within specified cost categories and a review of the fiscal impact of the new system on the General Fund.

(3) Not later than January 1, 2007, to the extent information is available for the three years immediately preceding the

implementation of this article, the department shall provide baseline information in a report to the Legislature on all of the following:

(A) The number and percent of freestanding skilled nursing facilities that complied with minimum staffing requirements.

(B) The staffing levels prior to the implementation of this article.

(C) The staffing retention rates prior to the implementation of this article.

(D) The numbers and percentage of freestanding skilled nursing facilities with findings of immediate jeopardy, substandard quality of care, or actual harm, as determined by the certification survey of each freestanding skilled nursing facility conducted prior to the implementation of this article.

(E) The number of freestanding skilled nursing facilities that received state citations and the number and class of citations issued during calendar year 2004.

(F) The average wage and benefits for employees prior to the implementation of this article.

(4) Not later than January 1, 2008, the department shall provide a report to the Legislature that does both of the following:

(A) Compares the information required in paragraph (2) to that same information two years after the implementation of this article.

(B) Reports on the extent to which residents who had expressed a preference to return to the community, as provided in Section 1418.81, were able to return to the community.

(5) The department may contract for the reports required under this subdivision.

(d) This section shall become inoperative on July 31, 2008, and as of January 1, 2009, is repealed, unless a later enacted statute, that is enacted before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed.

14126.035. (a) This article shall remain operative only as long as Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code, which imposes a skilled nursing facility quality assurance fee continues as approved by the federal Centers for Medicare and Medicaid Services pursuant to

Section 1324.27 of the Health and Safety Code.

(b) In the event of a final judicial determination made by any state or federal court that is not appealed, or by a court of appellate jurisdiction that is not further appealed, in any action by any party or a final determination by the administrator of the Centers for Medicare and Medicaid Services, that federal financial participation is not available with respect to any payment made under the methodology implemented pursuant to this article because the methodology is invalid, unlawful, or is contrary to any provision of federal law or regulations, or of state law, this section shall become inoperative.

SEC. 6. (a) The following amounts are hereby appropriated to the State Department of Health Services for expenditure to fund an increase to the 2004-05 skilled nursing facility Medi-Cal reimbursement rate consistent with the existing rate methodology in the Medicaid state plan:

(1) The sum of one hundred six million seven hundred eighty-one thousand dollars ($106,781,000) from the State Treasury.

(2) The sum of one hundred six million seven hundred eighty-one thousand dollars ($106,781,000) from the Federal Trust Fund.

(b) The sum of two million dollars ($2,000,000) for the 2004-05 fiscal year and one million dollars ($1,000,000) for the 2005-06 fiscal year is hereby appropriated to the State Department of Health Services from the General Fund for expenditure for purposes of implementing Section 14126.031 of the Welfare and Institutions Code.

(c) The sum of three hundred fifty thousand dollars ($350,000) for both the 2004-05 fiscal year and the 2005-06 fiscal year is hereby appropriated to the State Department of Health Services from the General Fund for expenditure for purposes of implementing Section 14126.033 of the Welfare and Institutions Code.

(d) The sum of two hundred thousand dollars ($200,000) for the 2005-06 fiscal year is hereby appropriated to the Bureau of State Audits from the General Fund for expenditure for purposes of implementing Section 14126.033 of the Welfare and Institutions Code.

SEC. 7. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the

meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to implement a comprehensive program to improve the quality of care provided in health facilities at the earliest possible time, it is necessary that this act take effect immediately.